Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
#01

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Date Received
FEBRUARY 6, 2007

MFDR Tracking Number
M4-08-3896-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 21, 2007: "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges…In this instance, the audited charges that remained after the last bill review by the insurance Carrier **$89,859.54**. Using the Stop Loss Method, the total amount that Vista Hospital of Dallas should have been reimbursed for the services it provided was **$67,394.66**. The prior amounts paid by the Carrier were **$9,354.00**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **$58,040.66**, plus any and all interest applicable."

Requestor's Supplemental Position Summary Dated February 15, 2013: "According to the Third Court of Appeals' opinion, a provider is entitled to reimbursement under the 'Stop Loss' exception in the Acute Care Inpatient Hospital Fee Guideline if the audited billed charges exceed $40,000 and if the surgery(ies) preformed on the claimant were unusually extensive and unusually costly…When these elements are proven, then the provider is entitled to be paid 75% of its billed charges. The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery, specifically an anterior cervical diskectomy and fusion at C5-C6 and C6-C7 along with placement of anterior cervical plate, and 2 cages. This complex spine surgery is unusually extensive for at least two reasons: first, this surgery as noted above required extensive spinal instrumentation and second, this surgery required the use of a microscope which is special equipment not normally used in this type of surgery. The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly for two reasons: first, it was necessary to purchase expensive implants for use in the surgery and required the use of a microscope; and second, additional trained nurses were required for this surgery, specifically two circulating nurses were used when typically only one is needed. Therefore, reimbursement should be in an amount which is 75% of billed charges which is $67,420.91."

Amount in Dispute: $67,394.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 14, 2007: "Copy of EOB attached. CCH held 1-9-07"

Response Submitted by: Liberty Mutual Insurance Company

Respondent's Supplemental Position Summary Dated February 28, 2007: We base our payments on the Texas Fee guidelines and the Texas Workers' Compensation Commission Acts and Rules. No additional

documentation has been received. Our position statement should be considered timely. Attached is a copy of the PLN 11 that was filed on this claim disputing treatment to the cervical area. A CCH was held 1/9/07 that determined that the cervical would be compensable. Payment was issued in the amount of $9484.08 on 2/9/07 for the services of 9/13/06. This included $130.08 interest."

Response Submitted by: Liberty Mutual Insurance Company

Respondent's Supplemental Position Summary Dated March 13, 2007: "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensaiton Commission Acts and Rules. The charges of 9/13/06 to 9/14/06 were originally denied as not compensable with payment issued following the CCH, which determined that treatment to the cervical spine is compensable for the injury on 3/9/06. The charges were audited and the stop loss was not applied per Medical Dispute newsletter of April 2005, which explains clearly the circumstances under which the stop loss would apply. The stop loss is to be used for unusually costly services as established in Rule 134.401(c)(6). Per subsection A, to be considered 'unusually costly services' the admission must: (1) Exceed $40,000 in total audited charges and (2) Involve 'unusually extensive services' such as complications infections or multiple surgeries. The submitted documentation has been reviewed but no documentation was found to indicate 'unusually extensive services'. The stop loss method will be applied only when both requirements are met. Otherwise payment is issued according to the per diem rate and carve-out methodology described in rule 134.401 (c). The TX Fee Schedule per diem rate is $1118.00. Reimbursement is for 1 day plus implants at cost plus 10%."

Response Submitted by: Liberty Mutual Insurance Company

Respondent's Supplemental Position Summary Dated March 22, 2013: "Based on the performed procedure, as well as the length of stay under the Acute Care Inpatient Hospital Fee Guidelines, the Requestor has invoked the Stop-Loss Exception contained within former Division Rule 134.401 and sought reimbursement in the amount of $89,859.54 for facility fees for dates-of-service September 13, 2006 through September 14, 2006. Respondent properly reimbursed $9,484.08. Per the DWC-60, the amount remaining in dispute is $58,040.86. Requestor has failed to meet the Austin Third Court of Appeals' mandate that, to qualify for reimbursement under the Stop-Loss Exception (former 28 Tex. Admin. Code §134.401(c)(6)) a hospital must demonstrate two things: the services it provided during the admission were unusually costly and unusually extensive, and its total audited charges exceeded $40,000…Because Requestor has not met its burden of demonstrating unusually extensive services, and the documentation adduced thus far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception, Respondent appropriately issued payment per the standard Texas Surgical per diem rate. No additional monies are due to the Requestor."

Response Submitted by: Hanna & Plaut LLP

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 13, 2006 through September 14, 2006	Inpatient Hospital Services	$67,394.66	$631.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out t``he procedures for resolving medical fee disputes.

4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- Z585 – THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE.
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SHEEDULE ALLOWANCE.
- Z695 – THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE.
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- F – FEE GUIDELINE MAR REDUCTION.
- Z989 – THE AMOUNT PAID PREVIOUSLY WAS LESS THAN IS DUE. THE CURRENT RECOMMENDED AMOUNT IS THE RESULT OF SUPPLEMENTAL PAYMENT
- W12 – EXTENT OF INJURY. NOT FINALLY ADJUDICATED.
- X206 – CARRIER DID NOT DEFINE THIS DENIAL REASON CODE ON THE EOB.

Issues

1. Does a compensability issue exist in this dispute?
2. Did the respondent provide sufficient explanation for denial of the disputed services?
3. Did the audited charges exceed $40,000.00?
4. Did the admission in dispute involve unusually extensive services?
5. Did the admission in dispute involve unusually costly services?
6. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the original explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "W12."
   The respondent states in the position summary that "Attached is a copy of the PLN 11 that was filed on this claim disputing treatment to the cervical area. A CCH was held 1/9/07 that determined that the cervical would be compensable. Payment was issued in the amount of $9484.08 on 2/9/07 for the services of 9/13/06."

The Division finds that the compensability issue has been resolved; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. 28 Texas Administrative Code §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006, state, in pertinent part, that " (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill…" and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division… " Furthermore, 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill." The requestor asserts in its position statement that:

   > "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges."

   Review of the submitted documentation finds that the explanation of benefits were issued using the division-approved form TWCC 62 and noted payment exception codes "W1, Z585, " for the services in dispute.

   These payment exception codes support an explanation for the reduction of reimbursement based on the Per Diem provision in former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of §133.240, and §133.2.

3. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $89,859.54. The Division concludes that the total audited charges exceed $40,000.

4. The requestor in its original position statement asserts that "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii)…This rule does not require Vista to provide evidence that the service provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery…for at least two reasons; first, this surgery as noted above required extensive spinal instrumentation; and second, this surgery required the use of a microscope which is special equipment not normally used in this type of surgery."

   The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. The requestor's position fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually

extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

5. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly for two reasons: first, it was necessary to purchase expensive implants for use in the surgery and required the use of a microscope; and second, additional trained nurses were required for this surgery, specifically two circulating nurses were used when typically only one is needed."

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the reqeustor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

6. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was one day. The surgical per diem rate of $1,118 multiplied by the length of stay of one day results in an allowable amount of $1,118.00.
   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
   - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $33,060.00.
   - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Per Unit	Cost + 10%
Cage Graft ACX	2	$1,500.00	$3,300.00
Bone Insert S Xpanse	2	$1,000.00	$2,200.00
Plate Ent-Cervical	1	$1,545.00	$1,699.50
Screw Wild Root	5	$295.00	$1,622.50
Screw Distraction	4	$400.00/box of ten or $40.00/each	$176.00
TOTAL	14		$8,998.00

- 28 Texas Administrative Code §134.401(c)(4)(C) states “Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed $330.05/unit for Thrombin USP TOP. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $10,116.00. The respondent issued payment in the amount of $9,484.08. Based upon the documentation submitted, additional reimbursement in the amount of $631.92 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $631.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		05/23/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.